Although Hussain and colleagues' technique[1] is indeed novel, it complicates mitral surgery by the need for aortic approach and adds a considerable amount of foreign material. It is indeed surprising that our publications have not been referred to in their article.

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Reply to the Editor:

We thank Dr Kumar for his comments and appreciate the opportunity to clarify the objectives of our technique.[1] We also acknowledge the technique described by Dr Kumar with autologous pericardium in a patient with severe mitral annular calcification and his favorable results at 13 years of follow-up.[2,3] Because the *Journal* limits references in reports on surgical technique to 5, we were unable to acknowledge this case report as well as the work of others who have published about mitral annular calcification.

Dr Kumar's technique focuses on avoiding calcium embolization, whereas ours focuses on prosthetic valve size, prosthesis seating, and avoiding periprosthetic leak. We débride calcium until it is possible to implant a prosthesis of acceptable size. The polytetrafluoroethylene felt washer sandwiched between the annulus and prosthesis[1] is an extension of the sewing ring, making it generous and soft, to distribute stress more evenly on all sutures and to help prevent periprosthetic leakage with softer tying of the sutures. We believe that our approach also reduces the risk of atrioventricular disruption or ventricular rupture and valve dehiscence.

Although we agree that the amount of foreign material should be minimized, the risk of infection is very low. Interestingly, Dr Kumar and his group[4] used polytetrafluoroethylene felt instead of standard annuloplasty rings in 710 of 818 patients who underwent mitral valve repair and reported only 3 cases of infective endocarditis at a mean follow-up of 44.9 ± 33.2 months. We have seen no cases of endocarditis and 1 minor perioperative stroke in our series. It is possible that Dr Kumar's concept of covering the raw, débrided area with autologous pericardium reduces the risk of embolism; however, this remains to be proved. Of course, the techniques could be combined.

Use of an annulus washer when replacing the mitral valve does not require an aortotomy. The aortotomy is added when there is a large amount of calcium on the ventricular side of the annulus anteriorly and in the areas of the two trigones, because this allows exposure of these areas and facilitates débridement of calcium and placement of valve sutures. The aortotomy does not complicate the operation; rather, it makes it easier, faster, and safer.

We greatly appreciate the opportunity to address the queries in Dr Kumar's letter.

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SURGICAL MANAGEMENT OF CEREBRAL MALPERFUSION WITH ACUTE TYPE A AORTIC DISSECTION

To the Editor:

We read with great interest the article by Abe and colleagues[1] about aortocarotid bypass surgery for malperfused left carotid artery complicated by acute aortic dissection. Their patient was a 57-year-old man brought to the hospital with right hemiparesis and loss of consciousness. Computed tomography of the chest showed acute type A aortic dissection, and the left carotid artery was occluded by a thrombosed false lumen. First, they performed the ringed graft anastomosis to the left common carotid artery. Then, this patient underwent ascending aorta replacement under hypothermic circulatory arrest and selective cerebral perfusion. After that, the ringed graft was anastomosed to prosthetic graft. The patient recovered well without any neurologic deficit.

We saw a similar type of acute aortic dissection. A 41-year-old man

FIGURE 1. Stent insertion was performed on both sides of the common carotid arteries.

had sudden syncope. Neurologic examination showed paraplegia and weakness of the right hand. Computed tomography showed the presence of type A aortic dissection with supra-aortic arch branch dissection. The left common carotid artery was occluded by the compression of thrombosed false lumen. Furthermore, infrarenal abdominal aorta was also occluded through compression by thrombosed false lumen. This patient underwent emergency total arch replacement and elephant trunk insertion under hypothermic circulatory arrest and selective cerebral perfusion. Five hours after surgery, the patient was extubated with a stable circulation; however, he reported right-sided weakness. Emergency computed tomography revealed that the left common carotid artery was still occluded and compressed by the false lumen as previously. The right common carotid artery was dissected as well, and the false lumen was patent. Other branches of the aorta were patent on this study. We performed carotid artery stent insertion on both sides of the common carotid arteries (Figure 1). The patient recovered without any neurologic deficit.

Management of cerebral malperfusion remains a surgical challenge.[2,3] If intervention had been delayed in our case, prognosis would not have been optimistic.[4] Our patient had multiple malperfused arteries, so we did not believe that distal malperfusion repair should be done before aortic arch surgery, because entry closure might be able to improve distal malperfusion. As Abe and colleagues[1] described in their article, central repair does not always improve organ malperfusion, as in our case. In this type of situation, stent insertion to the malperfused vessel could be another option.

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IS VIDEO-ASSISTED THORACIC LOBECTOMY SAFE AND SUCCESSFUL FOR LOCALLY ADVANCED NON--SMALL CELL LUNG CANCER?

To the Editor:

We read with interest the recent article by Villamizar and colleagues.[1] Their background is that video-assisted thoracoscopic surgical (VATS) lobectomy has been advocated as the criterion standard for early stages of non–small cell lung cancer (NSCLC), but its role in locally advanced stages remains to be determined. They therefore focused on patients treated with VATS lobectomy who had tumor size greater than 3 cm, central location, or nodal involvement to determine the predictive impact of these factors on perioperative morbidity. They compared the data from these patients with data from patients who had tumor size smaller than 3 cm, peripheral location, or N0 stage.

We congratulate Villamizar and colleagues[1] for their huge experience